PATIENT ACCOUNT NUMBER

Phys:	
Rec'd by:	

PATIENT INFORMATION (Please Print) **Today's Date** ____/____/____

Name_____
Last First M.I.

Address_____
Street Apt # City State Zip

Home Phone (___)_____ **Cell Phone** (___)_____ Work Phone (___)_____

Email Address_____ S.S. #_____

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Date of Birth _____/_____/_____ Age_____ Sex_____

Employer_____ Address_____

Accompanying Parent (if minor) _____

SUBSCRIBER INFORMATION

Name_____
Last First M.I.

Address_____
City State Zip

Home Phone (___)_____ **Cell Phone** (___)_____ Work Phone (___)_____
Employer_____ Address_____

Date of Birth _____/_____/_____ Sex_____ S.S.#_____

INSURANCE INFORMATION (Please present insurance card at time of check-in.)

Primary Insurance Name _____
Ins. Address _____
Policyholder _____
Insured's ID# _____ Grp #_____
SS #_____ Date of Birth____/____/____
Relationship of patient to the Insured _____
Insured Employer Name _____
Insured Employer Address _____
Insured Employer Phone (____)_____

Secondary Insurance Name_____
Ins. Address _____
Policyholder _____
Insured's ID# _____ Grp #_____
SS #_____ Date of Birth____/____/____
Relationship of patient to the Insured_____
Insured Employer Name _____
Insured Employer Address _____
Insured Employer Phone (____)_____

PHARMACY of CHOICE _____ **PHONE** (____)_____
ADDRESS _____

Referring Doctor _____ **Family Doctor**_____
Address _____ Address _____
Phone _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants, if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physician.

In order to establish optimal relations with patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services **at the time they are rendered** unless you are in a prepaid plan in which we participate. For these patients, applicable copayments and deductibles will be collected **at the time of service**. We accept payment in the form of cash, check or credit card. **If your insurance plan denies payment, you will be responsible for payment to our office. In the event that your check is returned "insufficient funds" or your account must be turned over to collections, a $30.00 administrative fee will be added to your account.** Your signature below signifies your understanding and willingness to comply with this policy.

Signature / Guardian _____ **Date** _____/_____/_____